



*Improving care between healthcare settings*

## The Issue

Transitional care, defined as a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations and/or levels of care in the same location can often result in poor outcomes for Medicare beneficiaries in an increasingly fragmented environment. When the process is not coordinated properly, the beneficiary is left in a vulnerable state and at an increased risk of rehospitalization. In addition, the costs to Medicare for these potentially avoidable rehospitalizations are significant.

Approximately 19,000 Medicare beneficiaries are admitted each year to hospitals in Douglas and Sarpy counties; of those, nearly one in six are rehospitalized within 30 days.<sup>1</sup> Medicare patients report greater dissatisfaction related to discharge than to any other aspect of care measured by the Centers for Medicare & Medicaid Services (CMS). A Medicare Payment Advisory Commission study found that 75 percent of all 30-day hospital readmissions of Medicare patients in 2005 were potentially preventable. A two percent reduction in readmissions in the Omaha metropolitan area alone would save over three million dollars per year. These staggering statistics indicate there is a considerable amount of room for improvement and incentives for change.

## The Opportunity

Through a competitive procurement, CIMRO of Nebraska was awarded one of 14 contracts across the country by CMS to conduct a cutting-edge initiative to improve care transitions between healthcare settings. CIMRO of Nebraska's local project, CareTrek™, will be implemented in the Omaha metropolitan community. CareTrek provides an opportunity to significantly impact the healthcare experience for Nebraska residents and will focus on the following:

- Hospital and community system-wide interventions
- Interventions that target specific diseases or conditions
- Interventions that target specific reasons for readmission

CIMRO of Nebraska, a leader in care transitions, understands CareTrek will require a multidisciplinary and multiprovider effort. CareTrek will bring together appropriate healthcare providers, stakeholders and community organizations to develop and implement an evolving intervention plan to reduce rehospitalization among Medicare beneficiaries residing within Douglas and Sarpy counties. With hospitals as the drivers of change, the goal is to implement sustainable care models to reduce unnecessary hospital readmissions by addressing patient medication management, patient self-management, post-discharge follow-up and plans of care for patients who move across healthcare settings.

## Role of CIMRO of Nebraska

CIMRO of Nebraska is accountable for ongoing project management and facilitation of CareTrek. CIMRO of Nebraska will assist providers and the community in creating resources for more effective transitions and in implementing improvement activities beyond the period of hospital discharge. Workflow analysis, data, tools and technical assistance will also be provided to CareTrek participants.

CIMRO of Nebraska is Nebraska's Medicare quality improvement organization (QIO) under contract with CMS to work with providers to improve the quality of care for Medicare beneficiaries.

<sup>1</sup> Source: Medicare claims data



## Resources for better healthcare

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**Questions?** Contact CIMRO of Nebraska at 800-458-4262 with questions or for additional information.